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1915(i) State plan Home and Community-Based Services

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The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Housing Stabilization Services - Transition; Housing Stabilization Services – Sustaining; Housing Consultation Services

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

☑	**Not applicable**
☐	**Applicable**
	Check the applicable authority or authorities:
☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

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☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved: Attachment 3.1-F describes operation of a managed care program under Section 1932 of the Act. The Attachment was originally approved as TN 05-03.

☐ **A program authorized under §1115 of the Act.** *Specify the program*:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.
(Select one):

☑ The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:

	The Medical Assistance Unit *(name of unit)*:	
✠	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	NH Department of Health and Human Services (DHHS) Division of Economic and Housing Stability Bureau of Housing Supports

○ The State plan HCBS benefit is operated by *(name of agency)*

a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be

delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	X	☐	☐	☐
2 Eligibility evaluation	X	☐	☐	☐
3 Review of participant service plans	X	☐	☐	☐
4 Prior authorization of State plan HCBS	X	☐	☐	☐
5 Utilization management	X	☐	☐	☐
6 Qualified provider enrollment	X	☐	☐	☐
7 Execution of Medicaid provider agreement	X	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	X	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	X	☐	☐	☐
10 Quality assurance and quality improvement activities	X	☐	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual

- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

In order to ensure conflict of interest standards are met, the state Medicaid agency will be responsible for eligibility and service authorization. Care Planning shall be done by the Regional Access Points, which are designated local points of entry into the Coordinated Entry System. Regional Access Points will use a common assessment to create a service plan and prioritize persons for available resources using the Coordinated Entry System policies and procedures. Care Planning shall be done independently from service provision. The Regional Access Points shall refer eligible individuals or households to local housing support organizations that provide direct services. The Supportive Housing Staff, employed by these organizations shall not provide any other service to the participant and his/her family other than the direct supportive housing services identified in the Care Plan developed by the Regional Access Point for pre-tenancy and tenancy support. Pre-tenancy and tenancy supports will be provided by Supportive Housing Staff either in person, by telephone, or virtually as needed by the participant. All other services needs will be referred back to the Regional Access Point, or to other community based services using 2-1-1 NH, the Unite US platform or other designated platform approved by the Department.

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	9/1/2021	8/31/2022	50
Year 2	9/1/2022	8/31/2023	60
Year 3	9/1/2023	8/31/2024	
Year 4			
Year 5			

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

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Financial Eligibility

1. ☑ Medicaid Eligible. *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.) 2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.
☑ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☑ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

X	Directly by the Medicaid agency
☐	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs based eligibility for State plan HCBS. *(Specify qualifications):*

The independent evaluation and reevaluation will be completed by the DHHS. The individual(s) performing this function shall have the following minimum qualifications;
a. A bachelor's degree in the social services or related field.
b. At least 2 years' experience in the housing, mental health or social services field.
c. Demonstrates an understanding of the housing system, community-based services, and behavioral health system and its components.
d. Demonstrates an understanding of the complexity of co-occurring disorders and the impact this has on a person's housing stability.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

NH DHHS will evaluate eligibility and re-determination and perform the independent evaluation of needs based criteria.

Specific eligibility criteria are outlined in #5 below.

Once the evaluator has determined eligibility, the Regional Access Point will work with the individual and his/her team to develop an individualized Plan of Care (POC) that is consistent with Housing First, is strengths based, individualized, community-based, culturally and linguistically competent. Regional Access Points are designated local points of entry into the Coordinated Entry System. Regional Access Points will use a common assessment to create a service plan and prioritize persons for available resources using the Coordinated Entry System policies and procedures.

Housing First is a homeless assistance approach that is guided on the belief that housing is a basic need for people that should be met as quickly as possible, without any prerequisites or conditions beyond those of a typical renter. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and participating in supportive services, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life. Traditional homelessness programs have been based upon the assumption that people should not be placed into housing until they have resolved personal issues, such as diagnosis and treatment of a disability or training in independent living skills. Conversely, a Housing First approach assumes that people should start with stable permanent housing. They may then choose to address other life issues that may have contributed to their homelessness experience to maintain their ongoing housing stability. Supportive services (such as recovery resources or mental health treatment) are offered to support people with housing stability and individual well-being, but participation is not required as services have been found to be more effective when a person chooses to engage.

The flexible and responsive nature of a Housing First approach allows it to be tailored to help anyone. Individuals using a Housing First model have been shown to access housing faster and are more likely to remain stably housed. Each individualized POC will use the above approach to create a strengths based, individualized, community-based, culturally and linguistically informed action plan to obtain, or retain housing.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

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5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The criteria below is used to determine that a person is eligible for state plan HCBS if the person meets the following needs-based criteria:

Without receipt of these 1915i services, a person is eligible who is homeless or at-risk of being homeless, with a diagnosed disability, which substantially impedes the individual's ability to live independently, and could be improved by the provision of more suitable housing conditions.

Definitions for homeless and at-risk of homelessness are defined by the US Department of Housing and Urban Development.

• Homeless. (1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

• At risk of homelessness: An individual or family who: (i) Has an annual income below 30% of median family income for the area; AND (ii) Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the "homeless" definition; AND (iii) Meets one of the following conditions: (A) Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR (B)Is living in the home of another because of economic hardship; OR (C) Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR (D) Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR (E) Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR (F) Is exiting a publicly funded institution or system of care

• Is currently transitioning, or has recently transitioned, from an institution or licensed or registered setting for individuals experiencing a mental health disorder or substance use disorder into homelessness or an unstable housing environment as described above.

And meets the criteria for the definition of being a homeless individual with a disability.—

(A) IN GENERAL.—The term `homeless individual with a disability' means an individual who is homeless, as defined above and in section 103 in the The McKinney-Vento Homeless Assistance

Act as amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, and has a disability that—

(i)(I) is expected to be long-continuing or of indefinite duration;

(II) substantially impedes the individual's ability to live independently;

(III) could be improved by the provision of more suitable housing conditions; and

(IV) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;

(ii) is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or

(iii) is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.

6. X **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC waivers)**	**ICF/DD (& ICF/DD LOC waivers)**	**Applicable Hospital* LOC (& Hospital LOC waivers)**
The criteria below is used to determine that a person is eligible for state plan HCBS if the person meets the following needs-based criteria: Without receipt of these 1915i services, a person is eligible who is homeless or at-risk of being homeless, with a diagnosed disability, which substantially impedes	A person must meet one of the following categories of need: • Dependency in four or more activities of daily living; • Need the assistance of another person or constant supervision to begin and complete toileting transferring, or positioning, and the assistance cannot	A person must meet all of the following: • In need of continuous active treatment and supervision to participate in life activities; • Have a diagnosis of intellectual or developmental disability, or a related condition; • Require a 24-hour	A person must meet all of the following: • Need skilled assessment and intervention multiple times during a 24-hour period to maintain health and prevent deterioration of health status; • Have both

the individual's ability to live independently, and could be improved by the provision of more suitable housing conditions. Definitions for homeless and at-risk of homelessness are defined by the US Department of Housing and Urban Development. • Homeless. (1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution • At risk of homelessness: An individual or family who: (i) Has an annual income below 30% of median	be scheduled; • Significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention; • Need clinical monitoring at least once per day; or • The person lives alone, or would live alone or be homeless without his or her current housing type, and meets one of the following: • is at risk of maltreatment or neglect by another person, or is at risk of self-neglect; • has had a fall resulting in a fracture within the last 12 months; • has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.	plan of care; and • An inability to apply skills learned in one environment to a new environment.	predictable health needs and the potential for changes in condition that could lead to rapid deterioration or life-threatening episodes; • Require a 24-hour plan of care, including a backup plan, to reasonably assure health and safety in the community; and • Be expected to require frequent or continuous care in a hospital without the provision of CAC waiver services.

family income for the area; AND (ii) Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the "homeless" definition; AND (iii) Meets one of the following conditions: (A) Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR (B)Is living in the home of another because of economic hardship; OR (C) Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR (D) Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR (E) Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR (F) Is exiting a publicly funded institution or system of care			

• Is currently transitioning, or has recently transitioned, from an institution or licensed or registered setting for individuals experiencing a mental health disorder or substance use disorder into homelessness or an unstable housing environment as described above. And meets the criteria for the definition of being a homeless individual with a disability.— (A) IN GENERAL.—The term `homeless individual with a disability' means an individual who is homeless, as defined above and in section 103 in the The McKinney-Vento Homeless Assistance Act as amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, and has a disability that— (i)(I) is expected to be long-continuing or of indefinite duration; (II) substantially impedes the individual's ability to live independently; (III) could be improved by the provision of more suitable housing conditions; and			

(IV) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; (ii) is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or (iii) is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.			

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑**Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

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A person who is determined by the lead agency to be experiencing homelessness with a diagnosed disability as defined by HUD, and described in (5) Needs Based HCBS Eligibility Criteria, that is expected to be long-continuing or of indefinite duration. ;

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* One	
ii.	**Frequency of services**. The state requires (select one):	
	☑	**The provision of 1915(i) services at least monthly**

○ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: N/A

Home and Community-Based Settings

(By checking the following box the State assures that):

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1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

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The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. This may include the following settings:

1. A private home or apartment with parents, family, or legal guardian or living independently when age and developmentally appropriate. Private homes exclude those that are owned, leased or controlled by a provider of any health-related treatment or support services; or
2. A home or apartment that is a licensed family foster care home or a licensed treatment foster care home. These settings are the homes that are owned or leased by the individual foster parents and are community based and align with the Federal Administration for Children and Families (ACF) requirements for foster homes. **.** or
3. An independent living transitional housing for a young adult who requires additional behavioral health supports and services that are not furnished or provided by the independent living housing program. This setting is an apartment setting that allows the young adult full access to community and job or school setting, the young adults living in such programs are supported in increasing the participant's adult living skills and are required and expected to perform all activities of daily living. The support offered in these programs is limited to adult living skills. Any services and supports the recipient requires from the 1915(i) would not be furnished by independent living programs.
4. Respite care services for children and youth who require a more controlled setting may include an overnight stay at a community based group home or community based foster care setting as certified by the DHHS. This service is limited in duration, as described in the service section and is not intended to be the child or youth's living situation. The child or youth receiving respite services in a group home setting is still considered to be living in his/or her home as described above in 1 and 2.

Assurances set forth by the state that the HCBS are delivered in appropriate settings are;

1. Attestation as part of the HCBS state plan application/eligibility determination that the participant is living or will be living in an approved setting prior to the provision of HCB Services.
2. Quality Assurance activities conducted by the NH DHHS shall include a review of the Care Management Entity documentation that indicates the setting is in compliance for each participant.
3. Quality Assurance activities conducted by the NH DHHS shall include a site visit for a random sampling of participants each year.

Transition and consultation services by their nature, are individualized, provided in the community, the individual's private home or non-disability-specific setting and allow full access to the broader community according to a person's needs and preferences. People choose which services and supports they receive and who provides them. Providers of these services will not undergo the site-specific assessment/validation process. This aligns with the assessment of 1915(c) Housing Access Coordination services in the transition plan.

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Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. X There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. X Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. X The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Community Based Housing Navigators will be responsible for conducting a face-to-face assessment of an individual's support needs and capabilities. Housing Navigators are employed by the Regional Access Points (RAP) and have met all the requirements of being a housing navigator. Housing Navigators may assist applicants with gathering the necessary documentation needed to complete formal housing applications. Families, individuals, youth, and people experiencing chronic homelessness who require navigation support and are not already linked to an Outreach Worker or Case Manager able to provide this level of support will be matched to a Housing System Navigator as capacity allows.
Housing Navigators employed by the RAP must demonstrate the following:
Education:
i. Bachelor's degree from a recognized college or university with major study in social work, sociology, psychology, counseling, nursing or a related field; or
ii. A high school diploma or equivalency; and
a. Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who has lived experience in the homeless services system; and
b. Meets the training requirements for housing navigator.
Experience:
i. Two years of professional experience providing direct service to individuals, youth, or families experiencing homelessness in social work, psychology, human services, counseling, mental health or equivalent.
License/Certification:
i. Valid State driver's license and/or access to transportation with liability coverage as required by state laws for travel throughout the State of NH.
Upon hire, housing navigators must complete the required trainings within one year of hire date, including, but not limited to:
i. Orientation
ii. Regional Access Point training
iii. Case Conferencing training
iv. Coordinated Entry System training.

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

For recipients receiving Medicaid-funded case management, the recipient's case manager will be responsible for the development of the person-centered service plan. If the recipient does not already have an assigned case manager, one will be assigned by the Housing Navigator during the Plan of Care creation.

Assigned case manager are responsible to respond to the range of the participant's needs, including acting as the primary contact for applicants, which includes providing proactive help to facilitate applicants applying for assistance or accessing services from other providers.
Once a participant has been assigned a case manager, the identified case manager should provide services to include support for the following:
- Development of an individualized housing stability plan;

- Close work with housing providers regarding eligibility documentation/verification;
- Follow-up on referrals to housing to support enrollment;
- Completion of housing applications;
- Assistance with submitting rental applications and understanding leases;
- Housing search and placement, sometimes in conjunction with local Landlord Liaisons;
- Education and training on the role, rights and responsibilities of the tenant and landlord;
- Finding resources to support move-in (security deposit, moving costs, furnishings, other one-time costs);
- Ensuring living environment is safe and ready for move in (facilitate inspections);
- Assistance in arranging for/supporting move (set up utilities, moving arrangements, etc.);
- Work to address barriers to project/housing admissions (e.g., criminal record, credit report, utility arrears, and unfavorable references);

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Every person experiencing homelessness should be treated with dignity, offered at least minimal assistance, and participate in their own housing plan. Individuals, youth and families should be provided with ongoing opportunities for participation in the development, oversight, and evaluation of coordinated assessment and CES. People should be offered person-centered choices and solutions whenever possible. Components of this approach include:

- Engaging recipients, their representatives and other people chosen by the recipient;
- Providing information necessary for the participant to make informed choices and decisions in order to direct the process to the maximum extent possible. This may include training, referral options, and relocation options if desired;
- Is timely and occurs at a time and location convenient to the participant;
- Reflects cultural considerations and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient;
- Includes clear conflict of interest guidelines and strategies for solving conflict;
- Offers choices to the participant regarding the services and supports they receive and from whom;
- Includes methods for updating the service delivery plan; and
- Records the alternative HCBS settings considered by the participant.
- Use of an assessment process developed using trauma-informed principles, which are based in part on an applicant's strength, goals, risk, and protective factors;
- Use of tools and processes which are clearly explained and easily understood, provision for modifications to processes where needed for accessibility, and availability of interpretation, translation, and screening for applicants who are non-English speaking in order to provide a sustained focus on the provision of culturally and linguistically appropriate services;
- Provision of training for referral partners, assessment partners, and housing navigators regarding trauma-informed communication and minimization of risk and harm;

- Provision of choice to applicants regarding decisions such as location and type of housing, level and type of services, and other program characteristics, as well as assessment processes that provide options and recommendations that guide and inform applicant choice; and
- Clear and understandable referral protocols, which ensure that applicants will be able to easily understand to which program they are being referred, what the program expects of them, what they can expect of the program, and evidence of the program's rate of success.

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Case managers and providers of housing consultation services will assist the recipient in developing a person-centered plan by providing information regarding service options and choice of providers. Case managers and consultation service providers offer information regarding:

1) Service types that would meet the level of need and frequency of services required by the recipient and the location of services;

2) Enrolled service providers listed and, as needed, additional local providers qualified to deliver Housing Stabilization Services;

3) Provider capacity to meet assessed needs and preferences of the recipient, or to connect the recipient with a community partner if the provider does not provide the necessary service, or does not have immediate capacity.; and,

4) Other community resources or services necessary to meet the recipient's needs.

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8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service is made subject to the approval of the Medicaid agency):*

The State Medicaid Agency will review a sample of approved service plans annually to assess whether the needs of the participants are being addressed, identify best practices and quality improvement opportunities, and identify areas of technical assistance. Annual reviews will be incorporated into the annual Coordinated Entry System evaluation schedule, and will follow the standard followed by the Balance of State Continuum of Care, which reviews 25% of files for the given time period.Additional reviews will occur as needed to address issues of quality improvement that develop.

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

X	Medicaid agency	☐	Operating agency	☐	Case manager
☐	Other (*specify):*				

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Housing Stabilization Service - Transition
Service Definition (Scope)*:*	

Community supports that assist individuals to plan for, find, and move to homes of their own in the community including:

- Supporting the person in applying for benefits to afford their housing
- Identifying services and benefits that will support the person with housing instability
- Assisting the person with the housing search and application process
- Assisting the person with tenant screening and housing assessments
- Helping a person understand and develop a budget
- Helping recipients understand and negotiate a lease
- Helping the recipient meet and build a relationship with a prospective landlord
- Identifying resources to cover moving expenses
- Helping the person arrange deposits
- Ensuring the new living arrangement is safe and ready for move-in
- Remote support when required to ensure their housing transition
- Helping a person organize their move

Remote support is real-time, two-way communication between the provider and the participant. The service meets intermittent or unscheduled needs for support for when a participant needs it to live and work in the most integrated setting, supplementing in person service delivery. Remote support is limited to check-ins (e.g. reminders, verbal cues, prompts) and consultations (e.g. counseling, problem solving) within the scope of housing stabilization services. Remote support may be utilized when it is chosen by the participant as a method of service delivery. To meet the real-time, two-way exchange definition, remote support includes the following methods: telephone, secure video conferencing, and secure written electronic messaging, excluding e-mail and facsimile. All transmitted electronic written messages must be retrievable for review. Providers must document the staff who delivered services, the date of service, the start and end time of service delivery, length of time of service delivery, method of contact, and place of service (i.e. office or community) when remote support service delivery occurs. At the beginning of all remote support telephone or video calls, the participant will be asked their physical location and phone number in the event that either the call is dropped, or an emergency occurs and the provider needs to call emergency services. All services delivered via telehealth shall comply with all applicable state and federal law or regulation as allowed by the Medicaid program, and shall be reviewed and approved by the NH HIPAA compliance officer. Any conflict with the provisions of this section and federal law or regulation shall preempt and supersede any provision of this section.

Transition services **do not** cover :

- Deposits
- Food
- Furnishings
- Rent
- Utilities
- Room and board
- Moving expenses

Transition services cannot duplicate other services or assistance available to the person.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

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Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
X	Categorically needy *(specify limits):*
	Housing Stabilization-Transition services are limited to 150 hours per transition. Additional hours beyond this threshold may be authorized by DHHS Recipients must be planning to transition from their current setting to a new home in a community-based setting. These services may be provided in a non-compliant setting if the person will be moving into a setting that is HCBS compliant at move in. This service will only be provided to individuals transitioning to a less restrictive setting, and for individuals transitioning from provider-operated settings, the service is only provided to those transitioning to a private residence where the individual will be directly responsible for his or her own living expense. For persons residing in an institutional setting, services may be furnished no more than 180 consecutive days prior to discharge and providers may not bill for services until the recipient has transitioned to a community-based setting. Transition services are not covered when a recipient is concurrently receiving sustaining services. Limitations applicable to remote support service delivery of housing stabilization services: • Remote support cannot be used for more than 20% of all housing stabilization services in a calendar month. Requests for additional time will be reviewed by the Department. • Providers may not Bill direct support delivered remotely when the exchange between the service participant and the provider is social in nature; o Bill direct support delivered remotely when real-time, two-way communication does not occur (e.g. leaving a voicemail; unanswered electronic messaging); o Bill for the use of Global Positioning System (GPS), Personal Emergency Response System (PERS) and video surveillance to provide remote check-ins or consultative supports.
X	Medically needy *(specify limits):*

	Housing Stabilization-Transition services are set to a standard of 150 hours per year. Additional hours beyond this threshold may be authorized by the Office with justification for additional service needs. Recipient must be planning to transition from their current setting to a new home in a community-based setting. These services may be provided in a non-compliant setting if the person will be moving into a setting that is HCBS compliant at move in. For persons residing in an institutional setting, services may be furnished no more than 180 consecutive days prior to discharge and providers may not bill for services until the recipient has transitioned to a community-based setting. Providers must develop policies and procedures that shall be authorized by the State Medicaid Agency that ensure safeguards are in place to ensure providers do not bill for services until the recipient has transitioned. The State Medicaid Agency will confirm in MMIS that duplicate services are not being billed prior to authorizing payment. Annual reviews of financial records will take place during annual monitoring. Transition services are not covered when a recipient is concurrently receiving sustaining services. Limitations applicable to remote support service delivery of housing stabilization service: • Remote support cannot be used for more than 20% of all housing stabilization services in a calendar month. Requests for additional time will be reviewed by the office. • Providers may not bill direct support delivered remotely when the exchange between the service participant and the provider is social in nature; o Bill direct support delivered remotely when real-time, two-way communication does not occur (e.g. leaving a voicemail; unanswered electronic messaging); o Bill for the use of Global Positioning System (GPS), Personal Emergency Response System (PERS) and video surveillance to provide remote check-ins or consultative supports.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency: agencies that meet the housing stabilization service standards			

Individual: Individuals that meet the housing stabilization service standards			Individuals providing housing stabilization services must have: Knowledge of local housing resources. Completed housing stabilization services training approved by the Commissioner.
			Completed mandated reporter training which includes training on vulnerable adult law. Additionally, providers of housing stabilization services must pass a criminal background check.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency: Agencies that meet the Housing Stabilization service standards	New Hampshire Department of Human Services	Every five years
Individual: Individuals that meet the housing stabilization service standards	New Hampshire Department of Human Services	Every five years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

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Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Housing Stabilization Service - Sustaining
Service Definition (Scope)*:*	

Community supports that assist an individual to maintain living in their own home in the community including:

- Developing, updating and modifying the housing support and crisis plan on a regular basis
- Prevention and early identification of behaviors that may jeopardize continued housing
- Education and training on roles, rights, and responsibilities of the tenant and property manager

- Coaching to develop and maintain key relationships with property managers and neighbors
- Advocacy with community resources to prevent eviction when housing is at risk
- Assistance with the housing recertification processes
- Continuing training on being a good tenant, lease compliance, and household management
- Supporting the person to apply for benefits to retain housing
- Supporting the person to understand and maintain income and benefits to retain housing
- Supporting the building of natural housing supports and resources in the community
- Remote support when required to help the person retain their housing

Remote support is real-time, two-way communication between the provider and the participant. The service meets intermittent or unscheduled needs for support for when a participant needs it to live and work in the most integrated setting, supplementing in person service delivery. Remote support is limited to check-ins (e.g. reminders, verbal cues, prompts) and consultations (e.g. counseling, problem solving) within the scope of housing stabilization services. Remote support may be utilized when it is chosen by the participant as a method of service delivery. To meet the real-time, two-way exchange definition, remote support includes the following methods: telephone, secure video conferencing, and secure written electronic messaging, excluding e-mail and facsimile. All transmitted electronic written messages must be retrievable for review. Providers must document the staff who delivered services, the date of service, the start and end time of service delivery, length of time of service delivery, method of contact, and place of service (i.e. office or community) when remote support service delivery occurs. At the beginning of all remote support telephone or video calls, the participant will be asked their physical location and phone number in the event that either the call is dropped, or an emergency occurs and the provider needs to call emergency services. Providers will ask recipients who else is present in the room prior to starting the conversation to ensure participant privacy. Providers will remind participants that sensitive activities including toileting, dressing, etc. should not be occurring during remote calls to ensure privacy. All services delivered via telehealth shall comply with all applicable state and federal law or regulation as allowed by the Medicaid program, and shall be reviewed and approved by the NH HIPAA compliance officer. Any conflict with the provisions of this section and federal law or regulation shall preempt and supersede any provision of this section.

Sustaining services **do not** include:

- Deposits
- Food
- Furnishings
- Rent
- Utilities
- Room and board
- Moving expenses

Sustaining services cannot duplicate other services or assistance available to the person.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

X	Categorically needy *(specify limits):*
	Housing Stabilization-Sustaining services are limited to 150 hours annually. Additional hours beyond this threshold may be authorized by the Office. Limitations applicable to remote support service delivery of housing stabilization services: • Remote support cannot be used for more than 20% of all housing stabilization services in a calendar month. Requests for additional time will be reviewed by the Office. • Providers may not bill direct support delivered remotely when the exchange between the service participant and the provider is social in nature; o Bill direct support delivered remotely when real-time, two-way communication does not occur (e.g. leaving a voicemail; unanswered electronic messaging); Bill for the use of Global Positioning System (GPS), Personal Emergency Response System (PERS) and video surveillance to provide remote check-ins or consultative supports.
X	Medically needy *(specify limits):*

	Housing Stabilization-Sustaining services are limited to 150 hours annually. Additional hours beyond this threshold may be authorized by the Office. Limitations applicable to remote support service delivery of housing stabilization service: • Remote support cannot be used for more than 20% of all housing stabilization services in a calendar month. Requests for additional time will be reviewed by the Office. • Providers may not: Bill direct support delivered remotely when the exchange between the service participant and the provider is social in nature; o Bill direct support delivered remotely when real-time, two-way communication does not occur (e.g. leaving a voicemail; unanswered electronic messaging); o Bill for the use of Global Positioning System (GPS), Personal Emergency Response System (PERS) and video surveillance to provide remote check-ins or consultative supports.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency: agencies that meet the housing stabilization service standards as outlined in the Administrative Rules			Agency providers of housing stabilization services must assure all staff providing the service have:

			• Knowledge of local housing resources. • Completed housing stabilization service training approved by the Department of Health and Human Services as outlined in the Administrative Rules. • Completed mandated reporter training which includes training on Adult Protection law. Additionally providers of Housing stabilization services must pass a criminal background study.
Individual: Individuals that meet the housing stabilization service standards			Individuals providing housing stabilization services must have: • Knowledge of local housing resources. • Completed housing stabilization services training approved by the NH Department of Health and Human Services as outlined in the Administrative Rules. • Completed mandated reporter training which includes training on Adult Protection law. Additionally, providers of housing stabilization services must pass a criminal background study.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Agency: Agencies that meet the Housing Stabilization service standards	New Hampshire Department of Human Services	Every five years
Individual: Individuals that meet the housing stabilization service standards	New Hampshire Department of Human Services	Every five years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Housing Consultation Services

Service Definition (Scope)*:*

Housing Consultation: planning services that are person-centered and assist an individual with the creation of the person-centered plan. Recipients may also receive referrals to other needed services and supports based on the person-centered plan. The consultant monitors and updates the plan annually or more frequently if the person requests a plan change or experiences a change in circumstance. This service shall be separate and distinct from all other services and shall not duplicate other services or assistance available to the participant. Housing consultation services may only be billed after approval of the plan by the Office. System edits will be in place to prevent the payment of targeted case management services in the same month in which housing consultations services are billed.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

X	Categorically needy *(specify limits):*

	Housing consultation services are available one time, annually. Additional sessions may be authorized by the Office if the recipient becomes homeless or experiences a significant change in a condition that impacts their housing, or when a person requests an update or change to their plan. To avoid conflict of interest, an individual cannot receive housing consultation services and housing stabilization services from the same provider. Recipient must be living in, or planning to transition to a new home in a community based setting. These services may be provided in a non-compliant setting if the person will be moving into a setting that is HCBS compliant at move in. For persons residing in an institutional setting, providers may not bill for services until the recipient has transitioned to a community-based setting.
X	Medically needy *(specify limits):*
	Housing consultation services are available one time, annually. Additional sessions may be authorized by the Office if the recipient becomes homeless or experiences a significant change in a condition that impacts their housing, or when a person requests an update or change to their plan. To avoid conflict of interest, an individual cannot receive housing consultation services and housing stabilization services from the same provider. Recipient must be living in, or planning to transition to a new home in a community based setting. These services may be provided in a non-compliant setting if the person will be moving into a setting that is HCBS compliant at move in. For persons residing in an institutional setting, providers may not bill for services until the recipient has transitioned to a community-based setting.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency: Agencies that meet the housing consultation service standards as outlined in the Administrative Rules.			Agency providers of Housing Consultation services must assure staff providing the service have: • Knowledge of local housing resources and must not have a direct or indirect financial interest in the property or housing the participant selects. • Completed training approved by the as outlined in the Administrative rule. Additionally, providers of Housing Consultation services must apply the standards in defined in the Administrative Rule.

Individual: Individuals that meet the housing consultation service standards as outlined in the Administrative Rules			Individual providers of housing consultation services must assure they have: • Knowledge of local housing resources and must not have a direct or indirect financial interest in the property or housing the participant selects. • Completed training as outlined in the rule. Additionally providers of Housing Consultation services must pass a criminal background study. as outlined in the Administrative Rules

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency: Agencies that meet the housing consultation service standards as outlined in the Administrative Rules	New Hampshire Department of Human Services	Every five years
Individual: Individuals that meet the housing consultation service standards as outlined in the Administrative Rules	New Hampshire Department of Human Services	Every five years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure*

that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

X	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐

	☐	☐

5. Financial Management. (*Select one)* :

X	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. ***(****Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

X	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

X	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

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Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	***Service plans address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of plans reviewed that document services to address all of the person's assessed needs. • Numerator: Number of plans reviewed that address all of the assessed needs. • Denominator: Number of plans reviewed by Department staff.

Discovery Activity *(Source of Data & sample size)*	Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System.
	Sample Size: 8/30 Methodology[1] of all provider files. Performance Standard: 90%.[2]
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office will be responsible for monitoring service plans. For those service plans that do not comply with the performance indicators, the Office will work with providers to ensure remediation compliance takes place within 30 days of notice of the finding. Performance issues that require remediation will result in corrective action plans developed by the provider within 30 days of being informed of the finding. The Office will review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved.
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***Service plans are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of plans reviewed that are updated annually. • Numerator: Number of plans reviewed in which the most recent plan has been updated within the past 12 months. • Denominator: Number of cases re-evaluated. Performance Standard: 90%.

Discovery Activity	Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Homeless Management Information System. Sample Size: All cases with an annual re-evaluation.

[1] 8/30 file review methodology is used by the National Committee for Quality Assurance (NCQA) of health plans in evaluating health plan accreditation. Through this methodology a random sample of 30 files are selected. 8 files are reviewed for the particular standard. If all 8 files meet the standard, then the standard has passed. If less than 8 meet the standard, an additional 22 files are reviewed to evaluate the standard. https://www.ncqa.org/Portals/0/Programs/Accreditation/8_30%20Methodology.pdf?ver=2018-01-10-154243-267 [2] When applicable performance standards are listed. The Department reserves the right to adjust standards after initial baseline data is collected.

(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office will be responsible for monitoring service plans. For those service plans that do not comply with the performance indicators, the Office will work with providers to ensure remediation compliance takes place within 30 days of being informed about the find. Performance issues that require remediation will result in corrective action plans developed by the provider within 30 days of being informed of the finding. The Office will review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved.
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***Service plans document choice of services, and providers.***
Discovery	

Discovery Evidence *(Performance Measure)*	Percentage of plans reviewed that document the recipient's choice between/among services and providers. • Numerator: Number of plans reviewed in which participant choice was documented • Denominator: Number of plans reviewed by Office staff. Performance Standard: 90%
Discovery Activity *(Source of Data & sample size)*	Data Source: Referral and eligibility data manually tracked by Office staff through MMIS and the Homeless Management Information System. Sample Size: 8/30 methodology
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency

Frequency	every 5 years
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office will be responsible for monitoring service plans. For those service plans that do not comply with the performance indicators, the Office will work with providers to ensure remediation compliance takes place within 30 days of notice of the finding. Performance issues that require remediation will result in corrective action plans developed by the provider within 30 days of being informed of the finding. The Office will review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved.
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***Providers meet required qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of provider applications that meet required qualifications. • Numerator: Number of provider applications that meet all required standards • Denominator: Number of providers who have applied for 1915(i) services. Performance Standard: 100%

Discovery Activity *(Source of Data & sample size)*	All provider agency applications are reviewed prior to approval. Data Source: Provider enrollment data tracked by Department staff through MMIS. Sample Size: All providers applying to deliver 1915(i) services.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Every 5 years
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office verifies that providers initially and continually meet required certification standards and adhere to other standards prior to their furnishing housing stabilization services. The Office will review provider qualifications upon initial enrollment, and every five years thereafter, to ensure providers meet compliance standards. Providers who do not meet required certification standards will not qualify to provide housing stabilization services.
Frequency	Annually

(of Analysis and Aggregation)	
Requirement	***Settings meet the HCBS setting requirements as specified in this SPA***
Discovery	

	Discovery Evidence *(Performance Measure)*	In order to provide housing stabilization-sustaining services, providers must submit documentation attesting that the recipient lives in a HCBS-compliant setting. Measure #1: Percentage of recipients determined eligible in the past 12 months that have a provider attestation that recipient lives in an HCBS-compliant setting. • Numerator: Number of recipient files with the provider attestation. • Denominator: Total number of recipient files reviewed. Performance Standard: 100% Measure #2: Percentage of recipients who had a recertification in the past 12 months that have a provider attestation that meets HCBS settings requirements. • Numerator: Number of recipient files with the provider attestation. • Denominator: Total number of recipient files reviewed. Performance Standard: 100%
	Discovery Activity *(Source of Data & sample size)*	Department staff will review service plans to verify the recipient lives in a compliant setting. Data Source: Referral and eligibility data manually tracked by Office staff through MMIS and the Homeless Management Information System. Sample Size: All recipients of state plan HCBS.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Recipients residing in settings that do not meet the requirements described in this plan may not receive housing stabilization- sustaining services.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The SMA retains authority and responsibility for program operations and oversight***
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of corrective actions that were resolved over the course of the most recent review cycle. Numerator: Number of corrective actions that were resolved. Denominator: Number of corrective action plans issued/approved in the most recent review cycle. Performance Review: 90%
Discovery Activity *(Source of Data & sample size)*	The Office will collect & review regular reports as well as conduct random monitoring of service providers. Data Source: Data manually tracked by Department staff through the Housing Stabilization Data System.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office will work with provider to ensure remediation compliance takes place within a designated period. The corrective action plan includes a timeline and describes how service plans will be corrected.
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers***
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of claims paid to active providers during the review period in accordance with the published rate on the date of service. • Numerator: Number of claims paid to active providers at the correct rate. • Denominator: Number of housing stabilization service claims paid in the sample. • Performance Review: 90%
Discovery Activity *(Source of Data & sample size)*	Department staff will review a sample of paid claims from MMIS. Data Source: MMIS Claims data Sample Size: 8/30 file methodology for file review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office will engage in continuous and on-going review and development of MMIS claims edits to ensure claims are properly paid.
Frequency *(of Analysis and Aggregation)*	Semi-annual reports of MMIS claims and edit development
Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of providers who complete training on child protection, maltreatment of vulnerable adults, and responsibilities as mandated reporters. • Numerator: Number of providers who have completed training on child protection, maltreatment of vulnerable adults, and responsibilities as mandated reporters.

	• Denominator: Total number of enrolled providers of housing stabilization services. • Performance Review: 100%
Discovery Activity *(Source of Data & sample size)*	All provider agency applications are reviewed prior to approval. Data Source: Provider enrollment and eligibility data manually tracked by Department staff. Sample size: All provider applications are reviewed for mandated training.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency and contracted entity
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office has a process in place for reporting abuse and neglect that will be applied to the provider working with beneficiaries. All providers working directly with beneficiaries are required to take training addressing issues when working with vulnerable adults and how to report instances of maltreatment.
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***Eligibility Requirements: an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.***
Discovery	

Discovery Evidence *(Performance Measure)*	Measure #1: Percentage of applications for 1951(i) services in which the Office completed a determination of medical need. • Numerator: Number of applications with a completed determination of medical need. • Denominator: Total number of applications to the Office for 1915(i) services. • Performance Standard: 90%

Discovery Activity *(Source of Data & sample size)*	Office staff will review data from MMIS and the Homeless Management Information System to determine whether all recipients who submitted an application also received a determination of medical need. Data Source: Referral and eligibility data manually tracked by Office staff through MMIS and the Homeless Management Information System. Sample Size: All recipients of state plan HCBS.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office will be responsible for determinations of medical need. For those determinations that do not comply, the Office will work to ensure remediation takes place within 30 days.
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***Eligibility Requirements: the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately***
Discovery	

Discovery Evidence *(Performance Measure)*	Percentage of new recipients with a determination of medical need that included a review of all criteria. • Numerator: Number of cases reviewed that included a review of all medical need criteria. • Denominator: Number of new recipients' cases reviewed. • Performance Standard: 90%
Discovery Activity *(Source of Data & sample size)*	Office staff will review a sample of applications and compare the outcome of the medical need determinations to program policies to determine whether requirements were applied appropriately. Data Source: Referral and eligibility data manually tracked by Office staff through MMIS and the Homeless Management Information System.
	Sample Size: 8/30 Methodology
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office will be responsible for determinations of medical need. The Office will review the processes and instruments used for determinations annually, and ensure remediation actions for changing these processes and instruments take place within a designated period.
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	***Eligibility Requirements: the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS***
Discovery	

Discovery Evidence *(Performance Measure)*	Percentage of annual reevaluations for 1951(i) service in which the Office completed a determination of medical need. • Numerator: Number of reevaluations with a completed determination. • Denominator: Number of reevaluations submitted to the Office. Performance Standard: 100%
Discovery Activity *(Source of Data & sample size)*	Data Source: Referral and eligibility data manually tracked by Office staff through MMIS and the Homeless Management Information System. Sample Size: All cases with an annual re-evaluation.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency

Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office will prevent payment of services if the recipient has not received an assessment within the previous 365 days. The Office will continuously monitor systems edits to ensure claims are properly paid or denied.
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	Performance requirements: enrolled individuals will have an increase in placement into permanent housing.
Discovery Evidence *(Performance Measure)*	Percentage of enrolled individuals receiving 1951(i) services placed into permanent housing. • Numerator: Number of enrolled individuals that have obtained permanent housing. • Denominator: Total number of enrolled individuals.

	Performance Standard: An annual increase, following the HUD System Performance Measure standards.
Discovery Activity *(Source of Data & sample size)*	Data Source: Referral and eligibility data manually tracked by Office staff through MMIS and the Homeless Management Information System. Sample Size: All cases with an annual re-evaluation.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office will review the System Performance Measures for enrolled individuals annually, and ensure remediation actions for improved outcomes are completed through a 30 day Corrective Action Plan.
Frequency *(of Analysis and Aggregation)*	Annually
Requirement	Performance requirements: enrolled individuals will have a reduction in returns to homelessness.
Discovery Evidence *(Performance Measure)*	Percentage of enrolled individuals receiving 1951(i) services returning to homelessness after achieving housing stability. • Numerator: Number of enrolled individuals that have returned to homelessness. • Denominator: Total number of enrolled individuals. Performance Standard: An annual reduction, following the HUD System Performance Measure standards.

Discovery Activity *(Source of Data & sample size)*	Data Source: Referral and eligibility data manually tracked by Office staff through MMIS and the Homeless Management Information System. Sample Size: All cases with an annual re-evaluation.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Office will review the System Performance Measures for enrolled individuals annually, and ensure remediation actions for improved outcomes are completed through a 30 day Corrective Action Plan.
Frequency *(of Analysis and Aggregation)*	Annually

System Improvement:
(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)

Methods for Analyzing Prioritizing Need for System Changes Improvement	Roles and Frequency Responsibilities	Method for Effectiveness of	Evaluating Data and System
The state Medicaid agency will survey recipients, stakeholders, providers and organizations regarding the quality, design, and implementation of the services annually, in collaboration with the annual survey of the Coordinated Entry System. A team of program and policy staff from the State Medicaid Agency will review and analyze collected survey, performance measure, and remediation data. This team will make recommendations for systems and program improvement strategies. Problems or concerns requiring intervention beyond existing remediation processes will be targeted for new/improved policy and/or procedure development, testing, and implementation.			

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

X	Other Services (specify below)

Groups Covered

B. Optional Coverage Other Than the Medically Needy (continued)

[28.] 1915(i) State Plan HCBS

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may also cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

X No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups. *(Select all that apply):*

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.

Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*